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The relevance of social isolation to the community tenure of former mental patients

Sue Ellen Hargadon

College of William & Mary - Arts & Sciences

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THE RELEVANCE OF SOCIAL ISOLATION
TO THE COMMUNITY TENURE OF FORMER MENTAL PATIENTS

A Thesis

Presented to

The Faculty of the Department of Sociology
The College of William and Mary in Virginia

In Partial Fulfillment
Of the Requirements for the Degree of
Master of Arts

by

Sue Ellen Hargadon

1981

APPROVAL SHEET

This thesis is submitted in partial fulfillment of
the requirements for the degree of

Master of Arts

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DEDICATION

This thesis is dedicated to the memory of my parents,
Thomas and Mary Hargadon.

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ABSTRACT

It is generally noted in the literature that ex-mental patients tend to be socially isolated. Their opportunities for interaction and meaningful social participation are held to be greatly restricted. Because rehospitalization is a major concern in mental health today, the question arises of any possible relevance of social isolation to the length of community stay. The purpose of this study was to investigate empirically any association between social isolation and community tenure within a sample of readmitted chronic mental patients.

In using role theory as the analytic framework, isolation was defined as lacking integration into the social structure of the community. Operationally it was defined as having a restricted role repertoire. The research hypothesis predicted an inverse relationship would be obtained between isolation and length of community stay.

This study was a secondary analysis of a body of data gathered as part of a project investigating factors in rehospitalization at Eastern State Hospital. To measure isolation, an index composed of items from the questionnaire used in the rehospitalization project was constructed. In that isolation appears to be a multidimensional concept, the index measures isolation along several dimensions. Community tenure was measured in two stages: (1) as the number of days each subject spent in the community following most recent discharge and prior to this admission; and (2) as membership in one of three tenure groups. Based upon the number of days spent in the community, tenure group membership was determined as follows: Group 1 was less than or equal to 6 months; Group 2 was greater than 6 months but less than or equal to 18 months; and Group 3 was greater than 24 months.

No significant results were obtained from the statistical analyses. It is thought that this is largely accounted for by the inexact fit between the conceptual definition of isolation and the empirical indicators used to measure it. Another serious problem was that the sample contained only readmitted former mental patients, possibly effecting a distorted view of isolation not representative of former mental patients in general. Future research is indicated to resolve the question of any possible effects of isolation upon tenure. It is recommended that a complete sample be obtained, including non-rehospitalized as well as rehospitalized patients. Other research methods may discern critical levels of isolation which have an effect on length of community stay.

THE RELEVANCE OF SOCIAL ISOLATION
TO THE COMMUNITY TENURE OF FORMER MENTAL PATIENTS:
AN ANALYSIS OF ROLE REPERTOIRES

CHAPTER I

INTRODUCTION

The past twenty years have witnessed a considerable shift in the mental health values and attitudes in the United States. Since the early 1960's the movement towards community care and deinstitutionalization have been the dominant directions in the mental health professions. Legitimized by the Community Mental Health Centers Act of 1963, these changes have placed great pressures upon the large state mental institutions to rid their halls of persons who could be treated in a less restrictive community setting. Being dangerous neither to themselves nor others, and despite bizarre or inappropriate behavior, such individuals are required by law (cf. Donaldson v. O'Connor, 1974) to be returned to the community. And returned they are, only to enter the "revolving door" syndrome of admission-discharge-readmission. The Group for the Advancement of Psychiatry reports that 65% of all 1972 admissions to mental hospitals in the United States were readmissions (GAP, 1978). As emphasis upon deinstitutionalization and community mental health continues, the many problems and difficulties facing former mental patients returning to the community have received considerable attention. Given these mental health values, this chronic population presents an immense challenge, for the problem of maintaining such individuals in the community and stemming the tide of continued

readmissions remains unsolved. It is in this context of a chronic population subject to repeated rehospitalizations that the concept of social isolation becomes relevant.

It is generally noted in the literature that former mental patients living in the community are characterized as socially isolated (e.g., Freeman & Simmons, 1963; Pasamanick et al., 1967; Serban, 1975; Shean, 1978). For a variety of reasons, these individuals find their opportunities for social contacts and interaction severely limited. This segment of the population has been described as being marginal to the larger society and lacking in social integration (e.g., Fairweather, 1969). Numerous studies concur in this observation of a lack of "fit" on the part of former mental patients, but the question of what causes or contributes to the isolation of these persons remains unanswered. Lacking in the literature is an explication of what such an attribute means in terms of understanding the gestalt of a discharged patient. Weber's concept of verstehen is particularly apropos here, for an attempt to interpretively understand this phenomenon of social isolation may further the endeavor to explain its causes, its course, and its effects (Coser, 1971:221). Explanatory understanding is but a preliminary step towards causal explanation, in that it aids in obtaining "a grasp of the context of meaning within which the actual course of action occurs" (Weber, 1962:36). From there, such understanding must be incorporated into theoretic structures in order to provide valid knowledge.

In focusing upon isolation as a salient factor in understanding the community experiences of former mental patients, this thesis follows the lead of Durkheim's classic study of suicide. As demonstrated in

that early study, the integration of individuals in their communities has important implications for psychological well-being. Durkheim observed that "excessive individuation leads to suicide" (1951:217), suggesting the potential ill-effects of detachment from society for the individual. The focus of study in this thesis is a group of individuals who, by status definition and geographical location, have been detached from society. It is argued that upon returning to the community they remain detached or isolated and that such isolation adversely affects their tenure in the community.

It is intended here to explore more fully the dimensions of social isolation as it pertains to former mental patients living in the community. The community experiences of a sample of readmitted patients were examined to determine empirically the presence or absence of social isolation. Further, any relationship such isolation might have with community tenure was also addressed, in order to discern the relevance of social isolation to community adjustment.

In order to investigate these issues, a secondary analysis of a body of data gathered as part of a project exploring possible factors in rehospitalization at Eastern State Hospital was performed. The research project focused upon only those individuals who, upon admission, were found to have a history of previous hospitalization. The scope of the project was extensive and sought information on a variety of topics, from the individual's expectations prior to discharge to changes in symptomatic behavior preceding the key admission. An effort was made to procure a comprehensive profile of these individuals during their last stay in the community and therefore this body of data has

information relevant to the topic at hand. The sample of returning patients is organized into three groups, according to their last length of stay in the community: (1) those whose stay was 6 months or less; (2) those whose stay was longer than 6 months but less than or equal to 18 months; and (3) those whose stay was 24 months or longer. These temporal conditions were utilized because previous researchers (Freeman & Simmons, 1963; Pasamanick et al., 1967) had noted them to be significant in the community adjustment of ex-mental patients. Most of the failures in the Pasamanick community study occurred within 6 months of discharge (p. 104). Freeman and Simmons (1963) concluded, in retrospect, that one year after discharge was not sufficient time to reach any definitive statements concerning failure rates (p. 18). The cutoff point of 24 months allows for this finding and seems important in terms of a good prognosis for community adjustment and tenure. For this thesis, these groupings provide an opportunity to investigate the variable of social isolation across three critical levels of community tenure.

The variable of community tenure can also be measured as the number of days each subject remained in the community after last leaving the hospital. This measurement of tenure as "days at risk" provides continuous data which afford an opportunity to perform more extensive and thorough data analysis.

It is hoped that this analytic endeavor has contributed not only to a better understanding of social isolation but also to the situation of ex-mental patients in our communities here in southeastern Virginia. Intuitively, one suspects that, psychopathology notwithstanding, any

segment of a population described as socially isolated and lacking in social integration is going to face considerable difficulties and very substantial "problems in living." This problem has particular relevance for sociology, because it touches upon the issues of social integration and differentiation, issues critical to the discipline. If we can better understand the situation of this problematic population, particularly how they fit (or fail to fit) into the larger society, perhaps more effective interventions can be devised and the transition, adjustment, and tenure of ex-mental patients in the community may be facilitated.

CHAPTER II

PREVIOUS STUDIES

The bulk of sociological investigation into the relationship of social isolation and psychopathology has focused upon the relevance of isolation to the etiology of mental disorder. Early in the 1930's sociologists began to hypothesize that the cause of schizophrenia was not biological but social and grounded in the isolation of the individual, isolation being defined as a lack of or separation from intimate social contacts (Faris, 1934). Building upon that earlier work and Burgess' early ecological analysis of social organization in urban areas, Faris and Dunham (1939) looked to epidemiological factors to further investigate the isolation hypothesis. Burgess had previously noted in his study of Chicago that the greatest amount of social disorganization and attendant social problems could be found in the inner city (i.e., the Zone in Transition, Zone II). This disorganization decreased, however, as one moved out from the inner city toward the periphery (i.e., the Commuters' Zone, Zone V). In analyzing this observed relationship between social disorganization and urban areas, he conceived of the city as composed of "natural areas" radiating from the center in concentric zones. Postulating that one particular dimension of social disorganization (social isolation) would precipitate higher

incidences of one particular social problem (psychosis), Faris and Dunham mapped out the distribution of various types of psychoses across the concentric zones and subcommunities (i.e., census tracts) of Chicago. Their data obtained the predicted ecological relationship between the rate and incidence of psychosis and the concentric zones of the city. The socioeconomic characteristics of the subcommunities within the zones were related to both the rate and type of mental disorder within them.

Also utilizing census tracts as the unit of analysis, Jaco (1954) followed a slightly different tack and looked first to the incidence of schizophrenia and manic-depressive psychosis within the city of Austin, Texas. Hypothesizing that those communities with high rates of schizophrenia will also have a high degree of social isolation, he attempted to explicate the elements of social interaction that might be involved in isolation. He then examined two pairs of communities, one pair having high and low rates of schizophrenia and the other pair having high and low rates of manic-depressive psychosis. He compared these communities according to characteristics of isolation and concluded that in general the data appeared to support his hypothesis.

In their community research in New Haven, Hollingshead and Redlich (1958) found a relationship between the class structure and mental disorder. They observed that the lower, most disadvantaged social classes also had the highest proportion of treated psychoses.

While these research findings suggest support for the hypothesis that conditions of isolation precipitate serious mental disorder, the temporal relationship between the two variables remains problematic. An alternative explanation for the data presented is that those

individuals having mental disorders (as well as other marginal persons) move into these areas of the city. In other words, the conditions present in these urban areas do not cause mental disorders but more easily accommodate individuals with such disorders. This alternative explanation is commonly referred to as the "social drift" hypothesis, implying that persons having socially debilitating disorders tend to move down the class structure and that concomitant with this demotion in social status is a geographical relocation into less desirable, more socially disorganized urban areas. Longitudinal studies are needed to fully explain this observed relationship between isolation and less organized areas of large cities.

Utilizing more of an individual approach, Kohn and Clausen (1955) brought data to bear on the social isolation hypothesis. They examined the extent of social isolation in adolescence in a sample of first admission schizophrenics and manic-depressive psychotics. Defining social isolation as the "diminution or total absence of social interaction with peers" (p. 266), they concluded that such isolation is not a precipitating factor in either schizophrenia or manic-depressive psychosis. This finding led them to assert that the isolation noted in psychotic individuals comes about as a result of their difficulties in functioning in interpersonal relationships (1955:273). In other words, Kohn and Clausen propose that isolation is more often a concomitant (or result) of the disorder, not a precipitator.

Weinberg (1966-67) offers a social psychological perspective on the relevance of social isolation to mental disorder. Again the emphasis is upon schizophrenia and its onset, but Weinberg presents a discussion of

four basic types of isolation and conceptualizes them according to a continuum, ranging from an external situational condition to an inner developmental binding reaction (p. 40). He argues that the more dynamic, interpersonal isolation resulting from having been rejected by others is the most instrumental in the schizophrenic breakdown. Such rejection results in withdrawal and a concomitant lack of communication; the individual finds it increasingly difficult to sustain interpersonal relationships as his/her ability for effective role-taking is impaired and self-esteem greatly damaged. Extreme withdrawal (self-isolation) in the form of schizophrenia may occur and role-taking ability may be even more impaired in this process of non-participation. It is this line of analysis that suggests a point of departure for investigating the relevance of social isolation to mental disorders well into their course of development.

The research on social isolation presented heretofore offers considerable insight into both the nature of the concept and its relation to psychological disorder. It seems, however, that much of it has failed to address directly the variable of isolation and has instead inferred its presence or absence from other, gross indicators. (In view of the fact that a great deal of the research was epidemiological in nature, this is not surprising.) Moreover, most of the studies have focused upon the relevance of isolation to the onset of mental disorder, specifically schizophrenia and manic-depressive psychosis. In the immediate study, the concern is not with the onset of mental disorder but with the continuation of it; further, the data base utilized contains information on other disorders in addition to the two psychoses

mentioned above. Thus, a more encompassing view of mental disorder that tends toward chronicity is obtained.

CHAPTER III

THE THEORETIC FRAMEWORK OF THE ROLE CONCEPT

In order to discuss the concept of social isolation more clearly, role theory was used as a framework for assessing both the occurrence and relevance of isolation to the community tenure of ex-mental patients. It can be argued that to be socially isolated is to lack integration into the social structure. Such integration is effected through the enactment of a variety of roles and to lack integration is to exhibit a restricted role repertoire. Role theory thus lends itself to this discussion, offering a means of indexing as well as analyzing the social isolation of former mental patients.

The role concept is a familiar one not only in the social sciences but in the larger society as well. To speak of the "parental role," for example, has meaning for the sociologist and the salesperson alike. In this sense, then, the concept of role is socially identified as an entity, i.e. it has meaning and is recognized, in varying degrees of concreteness, as a social fact independent of individual social actors (Turner, 1962:22). Roles supply a major basis for locating individuals within the social structure of a community. Thus, the role concept provides a conceptual bridge between the individual social actor and the larger social structure (Rushing, 1964; Sarbin & Allen, 1968; Turner,

1968). This linkage of the individual and social structure is based in behavior, the essential focus of the role perspective.

In taking complex, interactive social behavior as its focus of study (Biddle & Thomas, 1966:17), role theory assumes in its perspective that behavior results from "the social prescriptions and behavior of others" and that variations in behavior "are expressed within the framework of these factors" (Biddle & Thomas, 1966:4). Implicit within this perspective are three basic assumptions: orientation, prescription, and complementarity (Rushing, 1964:47-48). Essentially these three assumptions assert that behavior is oriented toward and influenced by the normative order; that it is prescribed by the normative order; and that it is enacted in a context of social "others" (Rushing, 1964). From the role perspective, the behavior of the individual is examined

... in terms of how it is shaped by the demands and rules of others, by their sanctions for ... conforming and nonconforming behavior, and by the individual's own understanding and conceptions of what his behavior should be.

(Biddle & Thomas, 1966:4)

Within sociology, there are two basic perspectives in role theory, one structural in its emphasis, the other interactionist. Structural role theory, in the tradition of the anthropologist Ralph Linton, views role as a unit of social structure, a specified pattern of behavior. Interactionist role theory, following the work of George Herbert Mead, emphasizes the process of "taking the role of the other" within which one learns the appropriate patterns of behavior. Turner (1962:23) notes the difference in the two perspectives: "The idea of role-taking shifts emphasis away from the simple process of enacting a prescribed role to devising a performance on the basis of an imputed other-role."

The structural perspective takes the existence of roles as a cultural given, while the interactionist perspective emphasizes the relevant other in the processes whereby social roles emerge or are fashioned (Turner, 1962). In short, it is structure as opposed to process which differentiates the two perspectives.

A key concept in the role perspective is that of status. Status is defined as a socially identified position, a location in a system of social relationships, accompanied by specified privileges and duties (see Yinger, 1965; Thomlinson, 1966). Accompanying the recognized position is an expectation of a certain pattern of behavior, i.e. a role. This relationship between status (position) and role has led many to state that role is the acting out of status, that role is "the dynamic aspect of status" (Linton, 1936:114; Rushing, 1964; Thomlinson, 1965:8). This view of role is valid but often leads to vagueness and confusion between the two concepts and has resulted in many varying definitions of role (Turner, 1968). To minimize such confusion here, we follow Yinger (1965:99) in defining role as "a structured behavioral model relating to a certain position of an individual in an interactional setting."

This definition of role establishes the use of the concept in this study as following that of structural role theory, particularly in using role to operationally define social isolation. While interactionist role theory, in its emphasis upon process, might inform the topic at hand as well or perhaps better, the retrospective and "one-sided" nature of the data impose certain limitations on the theoretic perspective. That is, the data consist of in-patients' retrospective reports of their

most recent community experiences. Hence, any statements about actual interaction between the individual and his/her others must be inferred from these retrospective reports. No data are available which speak directly to interaction.

Before concluding this section on role theory, several subconcepts of role, relevant to later discussion of social isolation and community tenure, need be considered. Role enactment is often used synonymously with role behavior but it specifically refers to the actual enactment of the role (Sarbin, 1968), as opposed to the normative behavior patterns of which the role concept consists.

Another important concept in role theory centers around the multiple roles which an individual enacts during his/her everyday life. This set of roles may be termed a role repertoire (Cameron, 1950; Sarbin & Allen, 1968) and refers to the various patterns of behavior the individual enacts as a result of the positions he/she occupies in the social structure. This concept should be distinguished from the "role-set" of Merton, which refers to the "complement of role relationships in which persons are involved by virtue of occupying a particular social status" (Merton, 1957:110). Role repertoire is more akin to what Merton terms "status-set" in that they both refer to the multiple roles associated "with the various social statuses ... in which people find themselves" (Merton, 1957:111).

One final concept relevant to the immediate study is role strain. In his classic article on role strain, Goode (1960) enunciated the basic postulate that "the total role system of the individual is unique and over-demanding" as a result of role conflict and role overload

(p. 495). Asserting this as his basic premise, he elaborated on the various mechanisms or processes whereby an individual reduces the strain effected by his/her multiple, conflicting roles. There is an alternative perspective, however, which departs from Goode's normative, homeostatic view.

It has been argued (Cameron, 1950; Sarbin & Allen, 1968; Sieber, 1974; Spreitzer et al., 1979) that multiple roles do not necessarily and inevitably result in stress for the individual. Sieber (1974) proposes that role accumulation can be potentially rewarding rather than stressing. Among the possible positive outcomes of role accumulation he notes are role privileges, overall status security by means of buffer roles, resources for status enhancement and role performance, and enrichment of the personality and ego gratification (Sieber, 1974:569). For example, having multiple roles allows the individual a "buffer" of sorts, in that failure in one role may be compensated for by performance in another (Sieber, 1974:573). In exchange theory terms, Sieber argues that the rewards of role accumulation exceed the costs and thus result in a net gain for the individual (1974:569).

Along this line, several theorists (Cameron, 1950; Sarbin & Allen, 1968; Sieber, 1974; Spreitzer et al., 1979) have also examined the relevance of multiple roles to psychological well-being. Contrary to Goode's theory of role strain, their work suggests that having multiple roles may result in better mental health and psychological well-being. The assumption is made that enacting multiple roles enhances the individual's interpersonal skills and facilitates social interaction for him/her. Conversely, having a limited number of roles may present

serious problems for the individual. Along these lines, Cameron (1950: 465) posits that

the person whose repertory includes a variety of well-practiced, realistic social roles is better equipped to meet new and critical situations than the person whose repertory is meager, relatively unpracticed, and socially unrealistic.

This enhanced "social ability" can be theoretically attributed to more effective role enactment, i.e. role enactment that is appropriate, proper, and convincing (Sarbin & Allen, 1968:490). Effective role enactment depends, however, upon effective role taking (i.e., "taking the role of the other") because it is by this process that one learns what is appropriate, proper, and convincing role behavior (Sarbin & Allen, 1968:539). In sum, a restricted role repertoire leaves the individual ill-equipped to meet the interpersonal (role) demands of everyday life. And, conversely, a varied role repertoire is enriching and offers buffers against faulty role performances.

While not exploring the social psychological dimensions of the above hypothesis, Spreitzer et al. (1979) have presented empirical data which support Sieber's theory of role accumulation. Using a "modified probability sample of the noninstitutionalized, adult population of the United States," they sought to explore the relevance of the number of basic roles enacted to psychological well-being (p. 142). In conducting their analysis, they measured the number of roles enacted in terms of five "role spheres." Positing that these are roles commonly accumulated by the general public, they define these spheres as: spouse (currently married), parent (having preadult children in the household), worker (currently employed full-time), friend (spends at least one

social evening per month with nonrelatives), and church member (currently affiliated with a particular church or synagogue). The cumulative number of roles was then related to a measure of subjective well-being. Upon the basis of their findings, the authors concluded that involvement in multiple roles is not necessarily stressful for the individual. Role strain was not found to be an inevitable result of enacting multiple roles.

In applying the role perspective to the study of social isolation of former mental patients, the concepts of role enactment and status (position) have particular relevance. In the initial phases of becoming a mental patient, the individual's ability to function in society becomes questioned as a result of behavioral and/or cognitive deviance. Interpreting the process in terms of role theory, it is asserted that, essentially, the person's enactment of roles is evaluated in terms of appropriateness, propriety, and convincingness (Sarbin & Allen, 1968). Should the evaluation find the person's role enactments lacking in these characteristics, the label of "deviant" may be applied and processes of social control initiated to rectify or constrain the performance. If the individual is deemed severely impaired so as to be dangerous to him/herself or others, a finding of mental illness may result and commitment may be recommended. The person, because of unacceptable role enactment, thus finds him/herself removed from his/her community and admitted to a mental hospital. The role perspective posits that, at the same time, the individual is disengaged from his/her ordinary roles and ascribed a new role in society, that of mental patient.

It is argued here that the role disengagement process undergone by

those individuals defined as mentally ill in our society has grave implications for any possible future return to the community. In the role perspective, it is postulated that a record of faulty role-playing causes the individual to lose his/her place within society. He/she is defined as "mentally ill," given the new status of mental patient, and concomitantly relocated spatially to a mental hospital for treatment. Upon release, the person finds it difficult to reclaim the roles left behind. Rather, he/she is given an alternative niche outside of the mainstream of interaction, a "nonparticipant social position" (Fairweather et al., 1969:337). Such individuals are thus isolated within the community; that is, they are physically in the community but they are not part of any meaningful social participation. In terms of roles, this non-participant social position implies a restricted role repertoire. In the final phases of mental illness, the individual is termed "chronic" and finds that the only role he/she is able to enact is that of mental patient.

Implicit in the above discussion of role enactment's relevance to becoming a mental patient is the importance of the status of mental patient. It is proposed here that the role disengagement process mentioned above hinges upon this new status which the person acquires as a result of faulty role enactment. In the role perspective, the status of mental patient can be conceptualized as a "single overarching status" that restricts "the full range of role opportunities in a society [that] can be pursued" (Sieber, 1974:577). This is so, it is posited, because such a social status carries the connotations of unpredictability, unreliability and potential dangerousness. The mental patients thus

warrant a marginal position in society. Occupying this status taints the individual and most often has an adverse, permanent effect upon his/her position in society. Unlike physical illness, the concept of mental illness conveys a sense of irreversible damage in terms of social functioning. Individuals thus afflicted suffer a permanent demotion within the status structure of their community; their ability to enact age-appropriate roles is seen as inherently impaired. (Goffman (1963) has explicated this de-valuing process extensively in terms of the concept of stigma.) They are assigned a marginal position in society and a pervasive, generalized disability is attributed to them. Thus, it is proposed that interpersonal rejection and avoidance contribute to social isolation greatly because of the connotations which the status of mental patient conveys.

The above analysis suggests the usefulness of the role perspective in studying a very complex and dynamic process. In its emphasis upon behavior and structure, the role concept purports to link individuals to social structure and thus allows placement of individuals within that structure. Consequently, the role concept lends itself to an operational definition of social isolation in terms of the number of roles in an individual's repertoire. Utilizing the concepts of role enactment and social status, it may be possible to understand why former mental patients are observed to be isolated within their communities. Rather than dwelling upon individual psychopathology, an analysis oriented to the normative and prescriptive aspects of society may prove more fruitful. Since the role concept focuses upon behaviors and social positions, it is hoped that a less evaluative perspective on

the controversial phenomenon of mental disorder has been obtained.

CHAPTER IV

HYPOTHESIS

In reviewing the literature on social isolation, it becomes apparent that very little effort has been directed towards an explanation of this attribute, as it applies to ex-mental patients in the community. While many researchers describe this population as socially isolated, they tend to leave the matter at the level of description. In most studies, isolation seems to be defined in terms of social activities or the extent of an individual's friendship or familial network. Although one's friendship and leisure activities are important, it appears that such a focus of isolation yields an undue emphasis upon the term social, in the popular use of the adjective. With the concept of role as our focus, however, a more rigorous and perhaps meaningful understanding of isolation may be obtained. In addition, it may be possible to assess more explicitly whether the description of this population as isolated is a valid description.

Isolation, as argued above, can be understood in terms of an individual's role repertoire, as it indicates the links between the person and the social structure. By examining an individual's roles, it may be possible to determine to what extent and to what degree he/she is

integrated within the social milieu. The number of roles enacted by an individual has also been postulated to relate to psychological well-being (Sieber, 1974; Spreitzer et al., 1979). Cameron (1950) has argued that the larger and more varied an individual's role repertoire, the better able he/she is to meet the demands of daily social life.

Relating this line of argument to former mental patients in the community, it is reasoned that their social isolation, evidenced in their delimited role repertoire, ill equips them to deal with the many difficulties confronting them. Also, such individuals are likewise more susceptible to the stresses of daily life. Therefore, the more restricted their set of roles, the less able they are to adjust to life in the community. Thus, it is posited that those individuals with a shorter length of stay in the community would be characterized by a greater degree of social isolation, as evidenced by a restricted role repertoire.

Theoretically isolation is conceived of as the independent variable, knowledge of which allows prediction of community tenure, the dependent variable. Using the data as they exist, however, it is the values of tenure which were given and the values of isolation which we sought to determine. Operationally, therefore, tenure becomes the independent variable and isolation the dependent variable. It was hypothesized that in the "real world," however, the temporal relationship between the two variables would dictate that isolation be defined as the independent variable which influences tenure. An inverse relationship between the variables can be predicted both theoretically and operationally. The limitations of the data required, however, that any

directional hypothesis be stated in terms of tenure predicting isolation, a direction contrary to what would be expected in the community.

In terms of the null hypothesis, then, it was predicted that isolation would have no relation to tenure. Based on the review of the literature presented above, the alternative hypothesis was proposed that an inverse relationship would be obtained between social isolation and community tenure.

CHAPTER V

METHODOLOGY

In order to determine whether social isolation is related to the length of community tenure of ex-mental patients, a body of data collected as part of a research project at Eastern State Hospital was utilized. The project was a survey design and used a questionnaire to investigate the community experiences of individuals readmitted to Eastern State Hospital. While data were not collected specifically for determining the relation of social isolation to community tenure, the project was designed to explore a variety of factors which previous researchers had demonstrated to have some association with rehospitalization. Social isolation was one such factor and thus the data base has information relevant to the hypothesis under consideration. The body of data is quite large and has such an array of factors included that it will be some time before analysis of it can be completed and the findings translated into recommendations for action. Hopefully this analytic endeavor has aided in the possible utilization of these data, thus benefiting both Eastern State Hospital and the population it serves.

The sample from which the data were obtained was composed of 75 in-patients at Eastern State Hospital who met the following criteria:

(1) were between 18 and 65 years old; (2) had a record of at least one previous hospitalization; and (3) did not have a primary diagnosis of chronic alcohol or drug abuse, brain damage, personality disorder, or mental retardation. All patients were readmissions at Eastern State Hospital but did not necessarily receive their last discharge from this hospital. The roster of eligible patients was obtained from the Daily Hospital Census Report and an effort was made to contact all eligible patients within 21 days of admission. Individuals transferred from other facilities or agencies were not included, as this often would have violated the 21-day time constraint. Patients in the crisis unit were not contacted. As much as was possible the subjects were consecutive readmissions, although often, for reasons of economy of time, all eligible patients within a single building were contacted in order to canvas as many patients as possible within the 21-day time period. Because of the limited research staff (the number of researchers varied from as many as three, to as few as one at various times) and the periodic swell of readmissions, many eligible patients were not contacted within 21 days of admission; many were discharged or transferred to other facilities during this time as well. Those patients who met the study criteria and remained in hospital longer than 21 days but were not contacted within that time were removed from the roster of eligible patients.

Having compiled a list of potential subjects, the procedure was then to contact the patients on the ward in order to administer a questionnaire developed specifically for this particular project. This instrument, "Psychiatric Rehospitalization Factor Checklist" (Bloch and

Rockwell, © 1979; see Appendix A), was designed as a face-valid, self-report measure and consists of questions drawn from an extensive rehospitalization literature review, as well as from several check-lists and structured interviews. (No studies of the validity and reliability of this instrument have been conducted to date.) After having explained the study to eligible patients, the researcher then asked them to participate in the project by first signing a consent form (Appendix B) and then completing the questionnaire. The research staff (2 males and 1 female) administered the questionnaire, giving the individuals a choice of either completing it themselves or having it read to them. (Because anti-psychotic medications can cause a blurring of vision, many subjects requested it be read to them.) The questionnaire required from 30 minutes to one hour for completion. Demographic data were obtained from the patients' ward charts as well as from the patients themselves, and were recorded on the Patient Record Review Form (Appendix C). After the data were collected, the subjects were assigned to one of three experimental groups ($N_1 = 23$, $N_2 = 27$, $N_3 = 25$), based upon the length of their last stay in the community. The organization of the data thus provided three temporal conditions for the variable of community tenure. Continuous data were afforded by the measurement of community tenure additionally as the number of days each subject spent in the community at risk for rehospitalization (Table 1).

The degree of social isolation for each subject was measured by an index composed of items selected from the questionnaire and record review form. Items which paralleled the "role spheres" delineated by Spreitzer et al. (1979) were chosen, supplemented by additional items

TABLE 1
DISTRIBUTION OF DAYS AT RISK ACCORDING TO TENURE GROUP

GROUP 1	GROUP 2	GROUP 3
3	187	740
14	196	804
25	200	815
29	215	839
36	220	893
37	250	936
57	253	958
59	261	1022
60	263	1025
62	280	1062
66	300	1180
77	313	1340
84	324	1487
93	325	1590
93	334	1805
115	353	1856
117	353	1917
129	371	1945
137	395	2044
141	408	2045
146	415	2145
171	439	2275
181	495	2609
	530	3407
	539	4076
	539	
	541	
Mean = 84	Mean = 344	Mean = 694

providing information on the subjects' most recent living situation and social activities. Because the population sampled in this study differs from that in the Spreitzer study (an institutionalized population versus a noninstitutionalized population), it may be that the nature of isolation will differ as well. Items that reflect isolation in one population may not be appropriate for the other population. For example, Spreitzer et al. reasoned that the parental role is one commonly enacted in the general public. For former mental patients, however, this role may not be a typical element of their role repertoire. The question of whether such an individual lives alone or with someone may more accurately reflect the variable of isolation. Thus, because the data base is incomplete with regard to the roles examined by Spreitzer et al. (information on the parental role is not part of this data base) and because the populations sampled differ, items were chosen to supplement those selected on the basis of Spreitzer's research. A complete list of the items selected is contained in Appendix D.

In that the variable of social isolation appears to be multidimensional, the index measures isolation along several dimensions. In order to obtain as much variation in the scores as possible, the variable of isolation was dichotomized according to the following procedure. It was established that any subject who evidenced isolation on any of the dimensions would be defined as isolated; all other subjects were considered to be not isolated. All dimensions and items within them were weighted equally. Complete details for scoring the index are contained in Appendix D.

CHAPTER VI

DESCRIPTION OF THE SAMPLE

The average age of all patients was 35 years at time of admission to the study. The age range was 18 to 62 years old. Both Groups 1 and 2 had an average age of 33 years, with respective ranges of 19 to 59 years old and 18 to 62 years old. Group 3 was slightly older with an average age of 38 years and a range of 23 to 58 years old.

The racial distribution of the total sample was 45% white and 55% black (see Table IV, Appendix E). Group 1 consisted of 52% whites and 48% blacks; Group 2 reversed this ratio, with 48% whites and 52% blacks. Group 3 contained considerably more blacks (64%) than whites (36%). This last finding is consistent with the findings of previous studies that black families, because of their lower position in the class structure, tend to tolerate more deviant behavior before rehospitalizing their family member (see Pasamanick et al., 1967:82-83).

With regard to sex, the total sample had slightly more males (52%) than females (48%) (see Table V, Appendix E). Both Groups 2 and 3 reversed this ratio and had 48% males and 52% females. In Group 1, however, there was a larger percentage of males (60%) than females (40%).

A large percentage (87%) of the patient sample was not married at the time of the study (see Table VI, Appendix E). Of these unmarried patients, 35 (48% of the total sample) were single and 30 (39% of the total sample) were either separated, divorced, or widowed. Only 13% of the entire sample reported being married. In Group 1 there were no married patients. Consequently, this group had the largest percentage of single (52%) and separated, divorced, or widowed (48%) patients. Group 2 had the lowest percentage (34%) of separated, divorced, or widowed patients. In Group 2 48% of the patients were single and 18% were married. Of all three subgroups, Group 3 had the largest percentage (20%) of married patients as well as the smallest percentage (40%) of single patients.

Over half (52%) of all patients reported having at least a high school education (see Table VII, Appendix E). Mean number of years education reported for the total sample was 11; the mode of number years education was 12. The ranges varied slightly across the groups: Group 1, range = 1-16 years (the largest); Group 2, range = 5-18 years; and Group 3, range = 7-16 years.

Using the data reported for years of education and the name of the patients' most recent job, the social position of each patient was computed using the Hollingshead Two-Factor Index of Social Position. This index allows placement of individuals within one of five social classes. The two lowest classes of the index (Classes IV and V) account for 89% of the total sample (see Table VIII, Appendix E); more than half (53%) of the patients were from the lowest class (Class V). There were no patients from Class I. Thus, the sample is composed

largely of individuals from the lower social classes. Group 3 particularly presents a lower socioeconomic profile, in that 60% of this group is from Class V (as compared to 52% and 48% in Groups 1 and 2). This group also had no members in Class II.

In brief, the sample is composed predominantly of unmarried patients, averaging 35 years of age. Race and sex distributions are roughly equal. The average number of years education completed is 11 and over half of the sample have graduated from high school. The patients are overwhelmingly from the lower social class.

The sample is composed largely of psychotic patients (71%), as diagnosed at their most recent discharge (see Table IX, Appendix E). Over half (59%) of all patients carry a schizophrenic diagnosis. On 21% of the sample information on their discharge diagnosis was unavailable. Of the patients for whom the diagnosis was available, 90% are psychotic and 75% are diagnosed schizophrenic. Group 3 clearly reflects the overall sample pattern, with a predominantly psychotic characterization (92%) and a high proportion (80%) of schizophrenic diagnoses. Well over half of each group (Group 1: 61%; Group 2: 59%) is diagnosed as psychotic. Only Group 1 has less than half (44%) of its members diagnosed as schizophrenic. This low representation of the schizophrenias in Group 1, however, may reflect the greater proportion of subjects (35%) in this groups for whom diagnosis was unavailable. Overall, the sample is characterized as predominantly psychotic, with schizophrenia being the most frequent diagnosis.

With regard to admitting diagnosis, for which the data are complete (see Table X, Appendix E), the sample is overwhelmingly psychotic

(91%) and largely schizophrenic (77%). The diagnosis of paranoid schizophrenia accounts for over a third (36%) of all patients. Within groups, schizophrenia is by far the predominant disorder: in Group 1, 83% are schizophrenic; in Group 2, 67% are schizophrenic; and in Group 3, 84% are schizophrenic. The patients in Group 3 are all psychotic by admission diagnosis. Group 2 presents an interesting case, with the least percentage of schizophrenics (67%), the least psychotics (82%), and the most neurotic patients (11% of the subgroup; 4% of the total sample). Clearly the psychotic profile of the sample obtained with discharge diagnosis is maintained and strengthened by admitting diagnosis.

Age at first hospitalization averaged 25 years for the total sample, with a range of 8 to 55 years old. For 16% of the sample this information was unavailable (Group 2 accounted for over half of the missing data). Both Groups 1 and 2 had an average age at first hospitalization of 24 years. Group 3 patients were slightly older at the time of their first admission, with an average age of 27.5 years.

The average number of previous hospitalizations for the total sample was 4. (The 4% of the sample for whom these data were unavailable is accounted for totally by patients in Group 1.) The number of previous hospitalizations ranged from 1 to 17. Group 1 averaged the most previous hospitalizations per subject (5); this group also had the largest range (from 1 to 17) of previous hospitalizations. Groups 2 and 3 had an average number of previous hospitalizations of 3.7 and 3.8, respectively.

For over half the sample (53%) information on the total length of

time spent in the hospital per subject was not available. Consequently, the figures reported must be viewed with caution as they represent only 47% of the total sample. Based on this information, the total time spent in hospital averaged slightly over one year (13 months). Group 1 patients (data unavailable for 65%) averaged slightly over one year in hospital (14.5 months). Group 2 patients (data unavailable for 74%) averaged over one and a half years (19 months) total time in hospital. Group 3 patients (data unavailable for 20%) had spent the least time in hospital, with an average of less than one year per patient (11 months).

In sum, the sample is composed of in-patients diagnosed predominantly as psychotic. These patients were first hospitalized, on the average, at the age of 25 years. They average approximately 4 previous hospitalizations and have spent an average of 13 months total time in the hospital during their lives. It should be noted, however, that these data were obtained from the ward charts, which were usually incomplete with regard to psychiatric histories.

CHAPTER VII

RESULTS

Two types of statistical analyses were performed, one using a cross tabulation of social isolation and tenure group and the other using the rank-ordered scores of social isolation and days at risk in the community. All data were ordinal in measurement, thus only ordinal level measures of association were appropriate for the analyses. In choosing a statistic for the cross tabulation analysis, one which indicates the proportional reduction of error in predicting one variable from the other seemed preferable. Such statistics allow a logical interpretation of their meaning in terms of the probability of making accurate predictions of some dependent variable (Nie et al., 1975:230; Loether & McTavish, 1976:212).

With the above factors in mind, the measure of association chosen for the cross tabulation analysis was Goodman and Kruskal's gamma (G). Gamma seemed most appropriate because (1) it deals with the problem of ties in ranking in either of the variables and (2) it is appropriate for use in either a square or rectangular "row X column" contingency table (Nie et al., 1975:228; Loether & McTavish, 1976:229). In that gamma is a "proportional reduction of error" statistic, its value is easily interpreted "as the probability of correctly guessing the order

of a pair of cases on one variable once the ordering on the other variable is known" (Nie et al., 1975:228).

For the correlational analysis performed with the number of days at risk for rehospitalization and the scores of social isolation, the Kendall rank-order correlation coefficient was computed. (For both this analysis and the cross-tabulation analysis, the actual computations were calculated with the computer, using the Statistical Package for the Social Sciences.) Kendall's tau was chosen over Spearman's rho (both are nonparametric coefficients of correlation suited for use with ordinal level measurements) because tau is more appropriate when the data contain a large number of tied ranks, while rho is more suited for data that are continuous. Nie et al. (1975) recommend using tau over rho when a large number of cases are classified into a relatively small number of categories, as is the situation with the isolation rankings in this study. In order to reduce the number of ties on the tenure variable, days at risk were utilized rather than tenure group membership because the former values were distributed with considerably more variance than the latter values (which varied only from 1 to 3 over the entire 75 cases).

An analysis of the results of the contingency table (Table 2) reveals that 51% of the total sample were identified as not isolated. The only tenure group in which the proportion of isolated subjects exceeds the non-isolated is Group 2 (59% isolated versus 41% non-isolated). For Group 1 almost the complete opposite proportions are obtained, with 61% non-isolated and 39% isolated. The splits in Group 3 (52% non-isolated and 48% isolated) approximate that in the total sample. In

TABLE 2
 PERCENTAGE DISTRIBUTION OF SOCIAL ISOLATION SCORES
 ACCORDING TO TENURE GROUP

Tenure Group	Social Isolation Scores		Total
	0	1	
	%	%	%
1	37	24	31
2	29	43	36
3	34	33	33
Total	100% (38)	100% (37)	100% (75)

Gamma = + 0.10540

computing the measure of association, gamma, for these results, the coefficient obtained was not significant at the .05 level of significance. The rank-order correlational analysis similarly yielded no results at the same level of significance. The null hypothesis is therefore not rejected and the two variables are assumed to have no association within the population sampled. From these results it may be deduced that the variable of social isolation, as conceptualized and measured in this study, does not correlate with community tenure within the sample.

CHAPTER VIII

DISCUSSION

The most obvious and straightforward conclusion to be reached from these results is that isolation and tenure have no relationship within the population sample. This inference assumes that social isolation has been correctly conceptualized and that the instrument used to measure it is a valid and sensitive one. In examining the scores obtained with this index, however, the problem of a restricted range becomes apparent. The distribution of the scores evidences very little variation and the question of how adequately the instrument measures the concept must be considered.

It should be remembered that the isolation index is based upon a questionnaire related to but not specifically designed for the purposes of the immediate study. While the rehospitalization questionnaire contains items which address the issue of social isolation, these items were not constructed upon the same conceptualization of isolation that is put forth here. There is to be expected, therefore, some lack of fit between the conceptual definition of isolation offered here and the empirical indicators used to measure it. This lack of fit is thought to account largely for the inability of the index to effectively discriminate between the isolated and non-isolated subjects.

The limitations arising from using an existing measuring device and related data base are inherent to almost any secondary data analysis. It is plausible to assume that such limitations account for the lack of results and to contend that the theoretical arguments proposed here are still valid. An additional factor to be considered, however, is that the conceptualization of isolation effected does not accurately reflect that existing within the population. In conceiving of isolation in terms of a role repertoire, it may be that former mental patients will consistently evidence the same degree of isolation. A perspective that emphasizes interaction and the process of role taking may have discriminated more effectively between critical and non-critical levels of isolation. In the immediate study, however, the retrospective and static nature of the data precluded such a conceptual definition.

Finally, an additional factor influencing the obtained results concerns the sample utilized to investigate the problem. Throughout the study reference has been made to former mental patients in the community and the possible relevance of social isolation to their community adjustment and tenure. In fact, however, the sample in this study represents only those former mental patients who have been rehospitalized. To determine more definitively any possible relationship between isolation and tenure, a sample which includes both readmitted and non-readmitted patients would be necessary.

In light of these problems of measurement and sampling, it is thought that the lack of significant results does not warrant an absolute rejection of any possible relation between isolation and tenure.

Rather, it is proposed that the inexact fit obtained between the role conception of isolation and the instrument used to measure the variable are partly responsible for the obtained lack of significant results. A further critical factor was the nature of the sample. Using only readmitted mental patients may have effected a distorted perspective upon isolation. It seems necessary to have non-readmitted patients as well in order to compare their degree of isolation with the readmitted patients before making any definitive statement on the effect of isolation on tenure.

CHAPTER IX

IMPLICATIONS FOR FUTURE RESEARCH

Future research should attempt to resolve the issues of sampling and measurement previously noted. The sample should include non-readmitted as well as readmitted patients and could best be obtained by following patients as they leave the hospital. A longitudinal follow-up study would provide critical data on the community experiences of both types of former patients. These data would inform the nature of the ex-patients' interaction in terms of role repertoires and role enactments, as well as the crucial process of taking the role of the other. Weinberg (1966-67) has postulated that the dynamic interpersonal isolation, which results from rejection by others, greatly contributes to the schizophrenic breakdown. It may be that this interpersonal rejection isolates the individual from meaningful social activities and contributes to the relapse of symptoms evidenced in regressive behavior. Research on family attitudes and interaction (Doll, 1976) reveals that former patients are physically accepted within the home but are emotionally and affectionately rejected. Thus, defining isolation solely in terms of the number of roles enacted may not give an accurate reflection of the isolation experienced by former mental patients. In addition to role repertoires, therefore, it seems

necessary to investigate role enactment as well. How former patients conceive of their roles is also of great importance. Because mental illness is largely defined in terms of behavioral deviance, it would seem informative to determine what behaviors former patients characteristically define as appropriate and proper for the roles they enact.

Measurement was a major problem in the immediate study. In making recommendations for future research, measuring isolation, and the appropriate methodology, are of prime consideration. A study which utilized open-ended interviews with extensive schedules, allowing for observation of subjects within their homes and communities, would seem to yield the most valid and informative data. Questions could be included which covered not only the extent of a subject's role repertoire but also the behaviors representative of his/her role enactment. The amount of time spent in interactive roles could be determined. The schedule could include items relevant to the subjects' conception of behaviors appropriate to roles they enact, as well as roles to which they aspire. A sentence completion test, tailored to commonly enacted roles in our society, would be one method of obtaining this information.

Isolation could then be measured not only by number of roles enacted but also by the amount of time spent in interactive roles. Intuitively it seems crucial to investigate whether the former mental patient has others with whom to interact who accept him/her and with whom he/she can share a context of meaning and values (see Fairweather, 1969, Chapter 18). This sort of information can be obtained only by in-depth interviews, conducted by sensitive and trained interviewers. A multi-dimensional conceptualization of isolation would be retained and

measured along these several dimensions suggested above.

Finally data should be gathered on the role of mental patient as part of the interview schedule. The attitudes of former mental patients toward the role of patient and behavior they feel is appropriate to or demanded by this role are important to a full understanding of their role enactments within the community. Noting that the status of mental patient can be an "overarching status ... [that restricts] the full range of role opportunities ... [which] can be pursued" (Sieber, 1974: 577), it is important to consider the role conflict and role discontinuity that can result from having once occupied this status. It may be that it greatly influences not only role opportunities but role enactment and role-taking ability as well.

In examining the results of this study, it is believed that the research conducted contributes to a fuller understanding of social isolation. The difficulties encountered in measurement underscore the multidimensionality of the variable. Isolation is a complex issue, involving not only objective elements but subjective ones as well. The research reported in this thesis has also emphasized the necessity of obtaining a full and complete sample. The social isolation of former mental patients has been a general assumption in the literature and perhaps the greatest contribution of this study is that it fails to support this general assumption. It questions this characterization of the population and, in doing so, suggests the need for future, more rigorous and well-designed studies. If the isolation of former patients can be empirically demonstrated, efforts may then be directed toward rectifying this condition.

Appendix A

Psychiatric Rehospitalization Factor Checklist
Bloch and Rockwell, © 1979

General Instructions: Please pay special attention to the period of time each question is asking about. The first part asks about things before you ever went to a hospital. The second part asks about your feelings during your previous hospitalization. The third part is the longest and asks about the time you spent in the community before this current hospitalization. The fourth part is the last and asks about your current situation. Please answer the questions as honestly as you can. Remember that all of your answers will be totally confidential. Please try to make sure that you mark every question and statement and do not skip any. There should be a ✓ or a 0 in every blank.

I. Part I concerns your life before you were ever hospitalized and before you received any psychiatric treatment at all. (✓ = applies to you; 0 = does not apply to you)

- ☐ 1. I got along well with my friends.
- ☐ 2. I did not like my home life.
- ☐ 3. I held a job.
- ☐ 4. I did not have a job but could have held one if I tried.
- ☐ 5. I did not have very many friends or acquaintances.
- ☐ 6. I frequently had arguments and quarrels with the people around me.
- ☐ 7. I usually did not have much to say to anyone.
- ☐ 8. I got along well with my family.
- ☐ 9. I had problems at school I could not work out.
- ☐ 10. I got into trouble sometimes.
- ☐ 11. I socialized a lot.

II. What people expect their lives to be like when they leave the hospital is often not the same as what actually happens. Part II asks you to remember what expectations you had right before you left the hospital the last time. (✓ = were true for you; 0 = were not true)

- ☐ 1. I expected to have some kind of regular job.
- ☐ 2. I expected to get along well with the people I would be living with.
- ☐ 3. I expected to have occasional disagreements with the people I would be living with.
- ☐ 4. I expected the people I would be living with to help me solve my problems.
- ☐ 5. I expected to help the people I would be living with solve their problems.
- ☐ 6. I expected that I would add to the problems of the people I would be living with.
- ☐ 7. I expected I could visit friends.
- ☐ 8. I expected someone would have to stay home with me all the time.
- ☐ 9. I expected to dress on my own.
- ☐ 10. I expected to feed myself without help.
- ☐ 11. I expected to remember when to take a bath or a shower.

III. The questions in Part III ask about your life during the last time you were out of the hospital and living in the community.

- A. The first questions ask about your living situation the last time you were out of the hospital. A person's living situation may sometimes be related to having to come back into the hospital. Please put an X in front of the situation you were living in right before you came back into the hospital this last time; check (✓) where you went to live the last time you left the hospital; and put a zero (0) in front of all the other living situations.

- ☐ 1. Parents' home (mother, father, or both)
- ☐ 2. With wife or husband
- ☐ 3. With my child or children
- ☐ 4. With brother or sister
- ☐ 5. With some relative other than those listed in 1-4
- ☐ 6. With a friend
- ☐ 7. With a boyfriend or girlfriend
- ☐ 8. Alone in an apartment
- ☐ 9. Halfway house
- ☐ 10. Landlord supervised boarding house
- ☐ 11. Hospital
- ☐ 12. School dormitory
- ☐ 13. Nursing home
- ☐ 14. On the streets
- ☐ 15. Jail
- ☐ 16. Hotel, motel, or rented room

- B. You may have lived in places other than the ones you marked above during your last time out of the hospital. Using the list of places above put the number of each additional place you lived in the space below.

-
- C. Please check (✓) the items listed below which describe how you feel about your most recent living situation. Put a zero (0) before the items which do not describe your feelings about your living situation.

- ☐ 1. It is in a good neighborhood.
- ☐ 2. I am allowed enough freedom.
- ☐ 3. It is shabby, rundown.
- ☐ 4. It is too noisy.
- ☐ 5. There is not enough privacy.
- ☐ 6. I get along well with the other people.
- ☐ 7. It is overcrowded.
- ☐ 8. I have friends whom I can talk to and who listen.
- ☐ 9. Others there expect too much of me.
- ☐ 10. Others there are overly protective of me.
- ☐ 11. Others there are lively and enthusiastic.

- D. Job situations vary a great deal from person to person. Some people work part-time, some full-time, and some not at all, for a variety of reasons. Check (✓) the following statements that describe your work record the last time you were out of the hospital. (✓ = applies to you; 0 = does not apply to you)

- ☐ 1. I was always out of a job after I left the hospital.
- ☐ 2. I was unemployed most of the time.
- ☐ 3. I was unemployed some of the time.
- ☐ 4. I worked steadily when I left the hospital.
- ☐ 5. My work was mostly part-time.
- ☐ 6. My work was mostly full-time.
- ☐ 7. I was a student, or a housekeeper, or was retired.
- ☐ 8. I was employed at the time I returned to the hospital.
- ☐ 9. I kept the same job.
- ☐ 10. I moved from one job to another.
- ☐ 11. I had training in particular job skills.
- ☐ 12. I worked in a sheltered workshop.

Please write the name of your most recent job: _____

- E. Sometimes physical problems can add to the stress people feel after leaving the hospital. Below is a list of physical problems you may have had the last time you were out of the hospital. (✓ = happened to you; 0 = did not happen to you)

- ☐ 1. I had a fever over 102°.
- ☐ 2. I had a broken bone.
- ☐ 3. I had an operation.
- ☐ 4. I was admitted to a general medical hospital for a physical problem.
- ☐ 5. I had a physical problem which required me to take medicine.
- ☐ 6. I had serious side-effects from medicine.
- ☐ 7. I was worried or felt anxious a great deal about my physical problems.

- F. Some people have many friends, while others like to keep pretty much to themselves. Check (✓) the statements below which best describe your social situation the last time you were out of the hospital. (✓ = describes your situation; 0 = does not)

- ☐ 1. I had many very close friends.
- ☐ 2. I had a few very close friends.
- ☐ 3. I had no close friends.
- ☐ 4. I had many acquaintances.
- ☐ 5. I had a few acquaintances.
- ☐ 6. I had no acquaintances.
- ☐ 7. I saw my friends often.
- ☐ 8. I never saw my friends.
- ☐ 9. I saw my friends occasionally.

When you were out of the hospital the last time, how many people lived in the same house with you? (If you lived alone, please write zero (0).)

_____ Number of people lived with me.

G. The following activities are some that people often do by themselves. Check (✓) the activities which you regularly did alone the last time you were out of the hospital (✓ = did every month; 0 = did not do every month)

- _____ 1. I went to movies by myself.
- _____ 2. I went to parties by myself.
- _____ 3. I went out to eat by myself.
- _____ 4. I went bowling by myself.
- _____ 5. I played solitaire (a card game).
- _____ 6. I went to church by myself.
- _____ 7. I participated in sports such as golf or jogging by myself.
- _____ 8. I went to dances by myself.
- _____ 9. I went to concerts by myself.
- _____ 10. I went to the library by myself.
- _____ 11. I went shopping by myself.
- _____ 12. I went on picnics by myself.
- _____ 13. I went to bars or lounges by myself.
- _____ 14. I went for drives by myself.
- _____ 15. I went for walks by myself.

H. These same activities are also done with friends. Put a check (✓) by the activities which you did regularly with friends the last time you were out of the hospital. (✓ = did every month; 0 = did not do every month)

- _____ 1. I went to movies with friend/s.
- _____ 2. I went to parties with friend/s.
- _____ 3. I went out to eat with friend/s.
- _____ 4. I went bowling with friend/s.
- _____ 5. I played cards with friend/s.
- _____ 6. I went to church with friend/s.
- _____ 7. I participated in sports such as softball with friend/s.
- _____ 8. I went to dances with friend/s.
- _____ 9. I went to concerts with friend/s.
- _____ 10. I went to the library with friend/s.
- _____ 11. I went shopping with friend/s.
- _____ 12. I went on picnics with friend/s.
- _____ 13. I went to bars or lounges with friend/s.
- _____ 14. I went for drives with friend/s.
- _____ 15. I went for walks with friend/s.
- _____ 16. I went to visit with friend/s.

- I. Many people use alcohol or street drugs to help them deal with problems in their lives. This section covers alcohol and drugs you may have used during your last time out of the hospital. Note: All answers on this questionnaire, including this part, will be kept completely private. (✓ = applies to you; 0 = does not apply to you)

- _____ 1. When I was out of the hospital, I sometimes drank alcohol to excess.
- _____ 2. When I was out of the hospital, I sometimes used drugs such as marijuana, amphetamines, narcotics, etc.
- _____ 3. When I was out of the hospital, I was drunk on alcohol or high on drugs.
- _____ 4. When I was out of the hospital, I had a drinking or drug problem that worried or upset my family or friends.
- _____ 5. When I was out of the hospital, I had a drinking or drug problem that interfered with my work or school.

- J. This section concerns psychiatric medications which may have been prescribed for you the last time you left the hospital. Examples of common psychiatric medications which are often prescribed are Valium, Thorazine, Navane, and Lithium. (✓ = applies to you; 0 = does not apply to you)

- _____ 1. When I left the hospital, I was prescribed psychiatric medication.
- _____ 2. After I left the hospital, I was prescribed psychiatric medication.
- _____ 3. I used the medication as directed.
- _____ 4. I took less medication than directed.
- _____ 5. I did not take medication at all.
- _____ 6. I took more medication than directed.
- _____ 7. I stopped taking the medication because of side-effects.
- _____ 8. I stopped taking medications for other reasons.

- K. This section is about your use of aftercare services while you were out of the hospital the last time. Aftercare services are the type of services you would receive at a community mental health center, an adult day care program, or an outpatient clinic. Check (✓) the items which are true for you and put a zero (0) in front of the items which are not true for you.

- _____ 1. I decided to go to aftercare on my own.
- _____ 2. Before I left, I was asked by the hospital to contact aftercare.
- _____ 3. The hospital contacted aftercare for me and I attended the first time on my own.
- _____ 4. Someone who works at the hospital went to aftercare with me the first time.
- _____ 5. Someone from an aftercare agency contacted me in the hospital before I left.
- _____ 6. Someone from an aftercare agency contacted me after I left the hospital.

- _____ 7. After attending aftercare, I decided on my own to stop attending.
- _____ 8. After beginning aftercare services, I stopped when the agency said I no longer needed services.
- _____ 9. I enjoyed attending aftercare.
- _____ 10. I missed several aftercare appointments.
- _____ 11. Aftercare helped me deal with my problems.
- _____ 12. I didn't need aftercare but went anyway.
- _____ 13. I lived near the aftercare agency.
- _____ 14. I had problems getting transportation to or from aftercare.
- _____ 15. I made contact with aftercare very soon after leaving the hospital.
- _____ 16. I waited to contact aftercare until I had problems.
- _____ 17. I waited to contact aftercare until I had gotten used to my new living situation.
- _____ 18. I visited aftercare very often, once or more a week.
- _____ 19. I did not visit aftercare very often, less than once a month.

L. There are several different kinds of aftercare services available to people while they are not in the hospital. Check (✓) the services below that you used before you came back to the hospital.
(✓ = services you used; 0 = services you did not use)

- _____ 1. I had appointments with a therapist by myself (individual psychotherapy).
- _____ 2. My family and I had appointments with a therapist (family therapy).
- _____ 3. I had group therapy with other patients (group therapy).
- _____ 4. I took prescribed medication (drug therapy).
- _____ 5. I had vocational rehabilitation therapy (voc. rehab. day center) or occupational therapy (OT).
- _____ 6. I received training in social and living skills.
- _____ 7. A mental health worker gave me psychological tests.
- _____ 8. I used another kind of aftercare service not listed above; please list these other kinds: _____

M. This section asks about losses you may have experienced while out of the hospital the last time. Although you may have experienced these losses sometime during your life, here we are interested only in those losses that happened during the last time you were out of the hospital (✓ = loss you experienced; 0 = loss you did not experience)

- _____ 1. I was separated or divorced from my husband or wife.
- _____ 2. My husband or wife died.
- _____ 3. My family moved away.
- _____ 4. My landlord or family asked me to leave.
- _____ 5. A close member of my family (other than husband or wife) died.
- _____ 6. I was separated from a close friend or boy/girlfriend.
- _____ 7. A close friend or boy/girlfriend of mine died.

- ☐ 8. My family went on vacation without me.
- ☐ 9. I lost or was laid off from my job.
- ☐ 10. The losses I checked caused me to worry and feel very badly.

N. This section concerns common feelings and problems which many people have at times. Listed below are feelings and problems you may have had in the weeks just before you came back into the hospital. They may or may not have been part of the reason you came back. In either case check the feelings that happened to you and put a zero in front of the feelings which did not happen to you. (✓ = applies to you; 0 = does not apply to you)

- ☐ 1. I had trouble remembering things.
- ☐ 2. I felt like someone or something was controlling my thoughts and actions.
- ☐ 3. I tried to physically hurt someone else.
- ☐ 4. I talked about wanting to hurt someone else.
- ☐ 5. I tried to hurt myself.
- ☐ 6. I told someone I wanted to hurt myself.
- ☐ 7. I felt like I had to keep moving or had to repeat an action over and over again.
- ☐ 8. I felt like laughing the whole day.
- ☐ 9. I felt hopeless or felt like crying the whole day.
- ☐ 10. I felt very angry the whole day.
- ☐ 11. I felt like someone or something wanted to harm me.
- ☐ 12. I got into arguments which led to fights or shouting matches.

O. The relationship you had with your closest family member or friend influenced how things were when you were out of the hospital. Think of your relationship with this person (listed at beginning of questionnaire) and check the items below which were true of the relationship. Your answers will be kept private and confidential. (✓ = applies to relationship; 0 = does not apply to relationship)

- ☐ 1. We got along well with each other.
- ☐ 2. We solved our differences in ways that were agreeable to both of us.
- ☐ 3. He/she interfered in my private life.
- ☐ 4. He/she interfered in my work.
- ☐ 5. We shared household responsibilities like cleaning, taking out the trash, or washing dishes.
- ☐ 6. He/she was too critical of me in general.
- ☐ 7. We usually agreed on how to save or spend money.
- ☐ 8. He/she was too demanding or controlling.
- ☐ 9. He/she was disappointed in me for not living up to his/her expectations.
- ☐ 10. He/she did not help me enough.
- ☐ 11. I felt friendly toward him/her.
- ☐ 12. He/she felt friendly toward me.
- ☐ 13. He/she expressed interest in me.

- _____ 14. I was able to express warmth and affection toward him/her.
- _____ 15. He/she was able to express warmth and affection toward me.
- _____ 16. I saw him/her at least 35 or more hours a week on the average.
- _____ 17. I saw him/her less than 35 hours a week on the average.

IV. Part four is the last part and, for the most part, asks questions about your feelings and abilities as they are now. Remember to put a ✓ or 0 in every blank and to answer as truthfully as you can.

A. Listed below are tasks that people often do during their daily lives. They are the sort of things that many people are able to do without help, while others may need some assistance in getting them done. Check the ones you can do without help. (✓ = can do without help; 0 = can do with help)

- _____ 1. I am able to get dressed in the morning.
- _____ 2. I am able to remember to take a shower or bath.
- _____ 3. I am able to use a telephone.
- _____ 4. I am able to fix a meal.
- _____ 5. I am able to shop for groceries.
- _____ 6. I am able to use a taxi or bus.
- _____ 7. I am able to budget or plan how my money can best be spent.
- _____ 8. I am able to clean around the house or yard.
- _____ 9. I am able to remember to shave, comb my hair, brush my teeth, and use deodorant.
- _____ 10. I am able to use appliances like ovens, toasters, stoves, or vacuum cleaners.

B. The following items contain thoughts and feelings that many people have. Please check (✓) all those that apply to you and put a zero (0) in front of those which do not apply to you.

- _____ 1. I have never intensely disliked anyone.
- _____ 2. I sometimes feel resentful when I don't get my way.
- _____ 3. There have been times when I felt like rebelling against people in authority even though I knew they were right.
- _____ 4. I sometimes try to get even rather than forgive and forget.
- _____ 5. There have been occasions when I felt like smashing things.
- _____ 6. I never resent being asked to return a favor.
- _____ 7. There have been times when I was quite jealous of the good fortune of others.
- _____ 8. I have almost never felt the urge to tell someone off.
- _____ 9. I am sometimes irritated by people who ask favors of me.
- _____ 10. I sometimes think when people have a misfortune they only got what they deserved.
- _____ 11. I have never deliberately said something that hurt someone's feelings.

- C. The amount of money you have to live on and the type of neighborhood you live in are important because they can affect the supports available to help you live in the community. Family income may include wages, welfare payments, social security payments, trust funds, retirement, VA benefits -- any money that you use to live on and support yourself. The following statements describe your relative financial situation. (✓ = applies to you; 0 = does not apply to you)

- _____ 1. My family is in the lower-income level (less than \$5,000 per person).
- _____ 2. My family is in the middle-income level (more than \$5,000 but less than \$15,000 per person).
- _____ 3. My family is in the upper-income level (more than \$15,000 per person).
- _____ 4. I earn most of the money in my family.
- _____ 5. The people in my neighborhood generally earn the same as we do.
- _____ 6. The people in my neighborhood earn more than we do.
- _____ 7. The people in my neighborhood earn less than we do.

Thank you for completing this survey. Your time and cooperation are greatly appreciated.

If you would like a summary of the results of this study, please put a check in this box: ☐

Address to send results to:

D

Appendix B

In-Patient Form of Consent to Research

I agree to participate in the Eastern State Hospital Research Department study investigating factors contributing to rehospitalization. Information gained from my participation will help determine what factors are most important in preventing rehospitalization and improving patients' chances of remaining in the community. I understand that my participation in the study is in the form of a questionnaire which takes approximately 30 minutes to one hour to complete. I also understand that there are no known psychological hazards or benefits from completing the questionnaire. I may refuse to answer any question, and I may discontinue my participation in the study at any time.

My relationships with close friends and relatives are important to an understanding of rehospitalization. I will give below the name of the person I was closest to (family member or friend) the last time I was out of the hospital and I authorize a member of the research staff to contact them. I give this relative or friend permission to release information to the researcher about me which will help pinpoint factors which prevent rehospitalization.

I understand that all information gathered will remain confidential and will be released to no one, including others questioned in the study, without my written permission. My identity and the identity of my family member or friend will remain anonymous.

My decision to participate or not participate in this study will in no way affect my hospital admission, stay, or discharge, or my status with the hospital or any related agency in any way.

I have been informed there is a Patient Protection Committee and that Chaplain Morgan is liaison to the Committee. The Committee has approved of and is monitoring this research. Any questions or comments may be referred to the Committee. The Committee operates independently of the administration at the hospital.

Family member or friend to be contacted is _____
Name

_____ Relationship	_____ Address	_____ Phone Number
-----------------------	------------------	-----------------------

My signature below indicates that I freely volunteer to participate in this research.

Signature

Date

Appendix C

Patient Record Review FormDate: / /

1. Name:
 - * 2. D.O.B.: / / age:
 - * 3. Race:
 - * 4. Sex:
 5. Prior Admission Date: / /
 6. Prior Discharge Date: / /
 7. Number of prior admissions:
 8. Prior discharge diagnosis:
 - * 9. Catchment Code:
 10. Marital status:
 11. Highest grade attained: 0 K 1 2 3 4 5 6 7 8 9 10 11
12 College 1 2 3 4 5 5+
 12. IQ
 13. Age at first hospitalization:
 14. Total length of time in hospitals:
 15. Social or living skills training while in hospital? Y N
 16. Was family counseling utilized while patient hospitalized? Y N
 17. Was patient referred to aftercare? Y N
- Type of referral:

Appendix D

Social Isolation Index

Five Dimension Index of Social Isolation:

I. Dimension: Living situation

1. Parents' home (mother, father, or both)
2. With spouse
3. With child or children
4. With sibling
5. With some relative other than those listed in 1-4
6. With a friend
7. With a boyfriend or girlfriend
8. Alone in an apartment
10. Landlord supervised boarding house
11. Hospital
14. On the streets
16. Hotel, motel, or rented room

Scoring: X in items 1-7 = not isolated
 X in items 8, 10, 11, 14, or 16 = isolated

II. Dimension: Employment

4. I worked steadily when I left the hospital.
8. I was employed at the time I returned to the hospital.

Scoring: ✓ both or either = not isolated
 0 both = isolated

III. Dimension: Friends

3. I had no close friends.
6. I had no acquaintances.
8. I never saw my friends.

Scoring: ✓ none = not isolated
 ✓ any = isolated

IV. Dimension: Activities

- G2. I went to parties by myself.
- G6. I went to church by myself.
- G8. I went to dances by myself.
- H3. I went out to eat with friend/s.
- H6. I went to church with friend/s.
- H8. I went to dances with friend/s.
- H11. I went shopping with friend/s.

Social Isolation Index

- H13. I went to bar or lounges with friend/s.
 H14. I went for drives with friend/s.
 H15. I went for walks with friend/s.
 H16. I went to visit with friend/s.

Scoring: ✓ any = not isolated
 ✓ none = isolated

V. Dimension: Marital status

Married = married, including stable common-law marriages
 Not married = single, divorced, separated, or widowed

Scoring: Married = not isolated
 Not married = isolated

Dimension I, Living situation (12 items)

Dimension II, Employment (2 items)

Dimension III, Friends (3 items)

Dimension IV, Activities (11 items)

Dimension V, Marital status (1 item)

Total number of dimensions = 5

Total number of items = 29

Methodological footnote:

Assuming isolation to be a multidimensional concept, the index was initially composed of five dimensions, as outlined above, based on the work of Spreitzer et al. (1979), supplemented by living situation and activities other than church attendance. It seemed appropriate to add these non-role items for the population because of the incompleteness of the data base. Spreitzer et al. had included the dimension of parent in their study and these data have no information on that kinship role. For each dimension, there were selected items from the questionnaire and these items and the method of scoring for each dimension are

explicated above. For each subject the number of dimensions in the index on which he/she was determined to be isolated was computed; this number was assigned to each subject as his/her isolation score. The range of possible scores was from 0 (no isolation) to 5 (high isolation). However, little variance in the isolation variable was obtained by this method of measurement, as the scores clustered around 2 and 3 (see Table I, this appendix). Noting that 79% (59) of the total sample was isolated on Dimension II (Employment) and 87% (65) of the total sample was isolated on Dimension V (Marital status), it was surmised that the items of the questionnaire used in these dimensions were not discriminating effectively between isolated and non-isolated subjects. These dimensions and their related items were then discarded from the index and a three dimension index of social isolation was obtained (see Table II, this appendix). Using the same procedure outlined above, the isolation scores were re-computed. The scores then had a possible range of 0 (no isolation) to 3 (high isolation). Again, very little variance was evidenced and the scores tended to cluster around 0 and 1 (see Table III, this appendix). At this point it was decided to dichotomize isolation, retaining the three dimension index. The procedure was to identify all subjects who evidenced isolation on any of the three dimensions as isolated; subjects who were not isolated on any dimension were defined as not isolated.

The rationale behind this measuring procedure was to determine the best method of obtaining information from a data base that had already been collected. In using an existing instrument, there was an inexact fit between the conceptual definition of isolation and the

empirical indicators utilized to measure it. Consequently, modifications in the index were deemed necessary in order to extract as much information from the data base as possible.

TABLE I
 PERCENTAGE DISTRIBUTION OF SOCIAL ISOLATION SCORES (5 DIMENSION INDEX)
 ACCORDING TO TENURE GROUP

Tenure Group	Social Isolation Scores						Total %
	0	1	2	3	4	5	
	%	%	%	%	%	%	
1	0	25	40	26	33	0	31
2	100	33	27	41	33	100	36
3	0	42	33	33	33	0	33
Total	100% (2)	100% (12)	100% (30)	100% (27)	100% (3)	100% (1)	100% (75)

Gamma = -0.00156

TABLE II
MODIFIED SOCIAL ISOLATION INDEX, THREE DIMENSIONS

-
-
- I Dimension: Living situation
 - II Dimension: Friends
 - III Dimension: Activities

Items within each dimension and scoring procedures are the same as for the original five-dimension index.

TABLE III
 PERCENTAGE DISTRIBUTION OF SOCIAL ISOLATION SCORES (3 DIMENSION INDEX)
 ACCORDING TO TENURE GROUP

Tenure Group	Social Isolation Scores				Total
	0	1	2	3	
	%	%	%	%	%
1	37	24	28.57	--	31
2	29	41	42.86	100	36
3	34	35	28.57	--	33
Total	100% (38)	100% (29)	100% (7)	100% (1)	100% (75)

Gamma = + 0.07441

Appendix E

TABLE IV
PERCENTAGE DISTRIBUTION OF RACE ACCORDING TO TENURE GROUP

Tenure Group	Black %	White %	Total %
1	27	35	31
2	34	38	36
3	39	27	33
Total	100% (41)	100% (34)	100% (75)

TABLE V
PERCENTAGE DISTRIBUTION OF SEX ACCORDING TO TENURE GROUP

Tenure Group	Male	Female	Total
	%	%	%
1	36	25	31
2	33	39	36
3	31	36	33
Total	100% (39)	100% (36)	100% (75)

TABLE VI
PERCENTAGE DISTRIBUTION OF MARITAL STATUS ACCORDING TO TENURE GROUP

Tenure Group	Single %	Married %	Sep/Div/ %	Widowed %	Total %
1	34	---	38	25	31
2	37	50	31	25	36
3	29	50	31	50	33
Total	100% (35)	100% (10)	100% (26)	100% (4)	100% (75)

TABLE VII

PERCENTAGE DISTRIBUTION OF EDUCATION ACCORDING TO TENURE GROUP

Tenure Group	Elem. (1-7 yrs) %	Some h.s. (8-11 yrs) %	Grad. h.s. (12 yrs) %	College (12 yrs+) %	Total %
1	27	32	23	41	31
2	55	40	23	35	36
3	18	28	54	24	33
Total	100% (11)	100% (25)	100% (22)	100% (17)	100% (75)

TABLE VIII
PERCENTAGE DISTRIBUTION OF SOCIAL CLASS ACCORDING TO TENURE GROUP

Tenure Group	Social Class					Total %
	I %	II %	III %	IV %	V %	
1	--	67	20	29	30	31
2	--	33	40	41	32.5	36
3	--	--	40	29	37.5	33
Total	----	100% (3)	100% (5)	100% (27)	100% (40)	100% (75)

TABLE IX
 PERCENTAGE DISTRIBUTION OF DISCHARGE DIAGNOSIS
 ACCORDING TO TENURE GROUP

Tenure Group	Diagnosis				Total %
	Psychotic %	Neurotic %	Other ¹ %	Unk %	
1	26	50	--	50	31
2	30	50	100	38	36
3	44	--	--	12	33
Total	100% (53)	100% (2)	100% (4)	100% (16)	100% (75)

¹Transient situational disturbances

TABLE X
 PERCENTAGE DISTRIBUTION OF ADMITTING DIAGNOSIS
 ACCORDING TO TENURE GROUP

Tenure Group	Diagnosis			Total %
	Psychotic %	Neurotic %	Other ¹ %	
1	32	25	17	31
2	32	75	50	36
3	36	--	33	33
Total	100% (65)	100% (4)	100% (6)	100% (75)

¹ Transient situational disturbances and affective disorders

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